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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CHRISTIANA STEPHEN EGWUNYE** **7055 Lennox Avenue #18** **Van Nuys, CA 91405** **Registered Nurse License No. 616144** Respondent.	Case No. 2010-433 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 27, 2003, the Board of Registered Nursing (Board) issued Registered Nurse License Number 616144 to Christiana Stephen Egwunye (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

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STATUTORY PROVISIONS

4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after expiration.

6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY PROVISION

10. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

11. On or about June 21, 2006, Respondent was working as a nurse in the post partum unit at Cedars-Sinai Medical Center in Los Angeles, California (hospital). At approximately 12:10 a.m., Patient A.D. was admitted to the post partum unit. Respondent was assigned to Patient A.D.'s care.

12. Patient A.D. had delivered triplets at approximately 10:00 p.m. on June 20, 2006. The first two babies born were delivered via spontaneous vaginal delivery. Due to complications with the positioning of the third baby, the physician used forceps to attempt to deliver the baby. When that method was unsuccessful, the physician used a vacuum and the baby was delivered.

13. At approximately 6:05 a.m. on June 21, 2006, which was around six hours after Patient A.D. was admitted to the post partum unit, a resident evaluated Patient A.D. and noted that she was tachypneic (breathing rapidly), pale and diaphoretic (perspiring profusely). Her blood pressure was 84/24. Patient A.D. was unresponsive and a code blue was called. Patient A.D. suffered an anoxic brain injury, which rendered her unable to take care of herself and requiring 24-hour care.

14. After the code was ended, Patient A.D. was taken into surgery where a hysterectomy was performed. According to the pathology report, there was a small laceration in Patient A.D.'s uterus. Patient A.D. had been bleeding internally. Approximately 1500 ml of blood had collected in her pelvic area. Patient A.D.'s hemoglobin level had dropped from 11.3 gm/dl to under 4 gm/dl.

15. During the six hours that Respondent was assigned to Patient A.D.'s care before the code was called, Respondent failed to monitor Patient A.D. appropriately and in a manner that met the standard of care, as follows:

a. Hospital policy and procedure required Respondent to take Patient A.D.'s vital signs (temperature, pulse, respiration and blood pressure) upon admission to the post partum unit. Respondent's notes indicate that Patient A.D.'s vital signs were "WNL [within normal limits] on admission." There is no other indication that Respondent actually took Patient A.D.'s vital signs at that time. Respondent did not record the vital signs in Patient A.D.'s medical record.

b. Respondent charted that she took Patient A.D.'s blood pressure at 2:25 a.m., approximately two hours after admission to the unit, and her blood pressure was 70/53. Patient A.D.'s blood pressure readings immediately after delivery of the triplets were in the 140s over 80s-90s. Respondent noted that she lowered the head of Patient A.D.'s bed and raised the foot of the bed. This is treatment for hypotension and impending shock. Although Patient A.D.'s blood pressure was low, Respondent did not take Patient A.D.'s pulse or respirations. Hospital policy and procedure required Respondent to take Patient A.D.'s pulse and respirations. It also required her to notify a doctor of Systolic Blood Pressure under 90 and/or Diastolic Blood Pressure under 60.

c. Respondent called a resident, who came to evaluate Patient A.D. Respondent charted that she took Patient A.D.'s blood pressure at 2:30 a.m., five minutes after the prior reading. The blood pressure was 77/41. The resident was present for the blood pressure reading. Respondent noted that Patient A.D. was "sweaty" and had "cold, clammy skin." These can be symptoms of hypotension and shock.

d. After administering IV fluids, Respondent took Patient's A.D.'s blood pressure again at 2:35 a.m., five minutes after the prior reading. The blood pressure was 83/53. According to Patient A.D.'s medical records, this was the last time that Respondent took Patient A.D.'s blood pressure before the code was called at approximately 6:05 a.m.

e. Per hospital policy and procedure, in a routine post partum case, Respondent would have been required to take Patient A.D.'s vital signs upon admission to the post partum unit, and then at two-hour intervals for the next four hours. Respondent failed to take Patient A.D.'s vital signs upon admission to the unit, and also failed to take them at approximately 4:35 a.m. According to the medical records, Respondent failed to monitor Patient A.D.'s pulse and respirations at all.

f. Closer and more frequent monitoring of Patient A.D.'s vital signs was warranted, given that her blood pressure was so low during the 10-minute period that Respondent monitored it, and Patient A.D. was exhibiting other signs of hypotension and shock, including nausea, sweating, and cold and clammy skin.

g. Moreover, Patient A.D. was complaining about pain, which she described as pressure on her rectum, and rated at a 7 on a scale from 1 to 10. The first pain medication prescribed, Toradol, did not relieve the pain. The resident prescribed Dilaudid, which is a strong opiate pain medication.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of gross negligence within the meaning of California Code of Regulations, title 16, section 1442, in connection with her treatment of Patient A.D. Complainant refers to and incorporates all of the allegations in paragraphs 15.a through 15.g, inclusive, as though set forth fully.

17. Respondent was grossly negligent in that she failed to monitor Patient A.D.'s vital signs at appropriate intervals, even though Patient A.D. was exhibiting symptoms of hypotension and shock. During the six hours that Patient A.D. was assigned to her care, Respondent took Patient A.D.'s blood pressure only three times, all of which were during a single 10-minute period. Respondent did not monitor Patient A.D.'s pulse and respirations at all.

18. Respondent failed to comply with the hospital's policy and procedure for monitoring vital signs in a routine post partum case, in that she failed to take Patient A.D.'s vital signs on at least two occasions during the period before a code blue was called for Patient A.D. This non-routine case warranted even more frequent monitoring of Patient A.D.'s vital signs.

19. Due to Respondent's failure to monitor Patient A.D.'s vital signs at appropriate intervals, the physicians were not provided with all of the information they should have had available to them to use in monitoring Patient A.D.'s condition. Before the code was called, Respondent only recorded Patient A.D.'s blood pressure during a single 10-minute period between 2:25 a.m. and 2:35 a.m. After 2:35 a.m., Respondent did not report to the residents any additional low blood pressure readings or any other issues with Patient A.D.'s vital signs. According to the medical records, Respondent did not monitor Patient A.D.'s vital signs for the three and a half hours before the code was called.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

20. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of incompetence within the meaning of California Code of Regulations, title 16, sections 1443 and 1443.5, in connection with her treatment of Patient A.D. Complainant refers to and incorporates all of the allegations in paragraphs 15.a through 15.g and 17 through 19, inclusive, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 616144, issued to Respondent;

2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/16/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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